TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Hidalgo County

MFDR Tracking Number
M4-17-2207-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
March 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. WCERA_WORKERS' COMPENSATION EXPECTED REIMBURSEMENT AMOUNT – DRG 548 - $13,414.72 (143%) = ERA $19,183.05. The reimbursement amount should be $19,183.05. Payment received was only $15,811.69, thus according to these calculations; there is a pending payment in the amount of $3,371.36."

Amount in Dispute: $3,371.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent requests an order that no further reimbursement is due, as the Carrier has paid the services made the basis of this response in accordance with Medical Fee Guidelines."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2016 through November 23, 2016	Inpatient Hospital Services	$3,371.36	$3,283.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 222 – Charge exceeds Fee Schedule allowance
   - 993 – Reduction is based on the Inpatient Fee Schedule
   - ANSIP12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 143 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is November 14, 2016 through November 23, 2016. The services were provided at Doctors Hospital at Renaissance. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount taken from the *Medicare Inpatient PPS Pricer* is $13,384.88. A "VBP" claim payment in the amount of $31.31 is then **subtracted** from $13,384.88, resulting in a facility specific amount of $13,353.57.

   "VBP" stands for Value-Based Purchasing (VBP) payment. Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. The Medicare VBP conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system.

   Pursuant to 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare

program. For that reason, the VBP amount does not apply and was therefore subtracted from the total indicated on the *Medicare Inpatient PPS Pricer.*

The total facility amount of $13,353.57, multiplied by 143% results in a facility-specific reimbursement amount of $19,095.61.

3. 134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 548, and that the services were provided at Doctors Hospital at Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $13,353.57. This amount multiplied by 143% results in a MAR of $19,095.61.
4. The total allowable reimbursement for the services in dispute is $19,095.61. This amount less the amount previously paid by the insurance carrier of $15,811.69 leaves an amount due to the requestor of $3,283.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,283.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,283.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		4/12/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.